U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LARRY W. FRANKLIN and DEPARTMENT OF THE NAVY, NAVY AVIATION DEPOT, Cherry Point, NC

Docket No. 99-637; Submitted on the Record;
Issued May 10, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS,
MICHAEL E. GROOM

The issue is whether appellant has greater than a 10 percent permanent loss of use of his right arm for which he received a schedule award.

On August 6, 1997 appellant, then a 54-year-old jet engine mechanic, filed a notice of traumatic injury and claim for compensation, alleging that on August 6, 1997 he sustained an injury to his right arm while lifting a heavy box of blades from the floor at the employing establishment. On April 15, 1998 the Office of Workers' Compensation Programs accepted appellant's claim for right biceps rupture.

To determine an appropriate award of compensation, the Office reviewed the treatment notes submitted by appellant on April 30, 1998 from Dr. Robert G. Blair, a Board-certified orthopedic surgeon and appellant's attending physician. In an April 2, 1998 note, Dr. Blair stated:

> "On physical exam[ination] there is no atrophy. When the patient abducts the shoulder there is an obvious slight lifting of the humeral head with lack of function in the long head of the biceps. There is intermittent crepitus throughout motion of the shoulder which I believe is secondary to the cuff degeneration and a complete rupture of the long head of the bicep. He cannot be rated on range of motion in the 4th *Guide[s] to [the Evaluation of Permanent] Impairment* section 3.1M due to other disorders of the upper extremity, Table 23 indicates that a mild subluxation can rate at a 20 percent impairment of the joint. There is also a 15 [to] 20 percent loss of strength on the basis of the tendon rupture. In essence there is no completely applicable portion of the *Guide[s]* to rate this particular individual and consequently as stated on page 63 under other musculosystem defects 'In a rare case severity of clinical findings may not correspond to the extent of the musculosystem defect as demonstrated with a varying of imaging techniques this might occur in a patient in whom a loss of shoulder motion does

> not reflect the severity of an irreparable rotator cuff tear as demonstrated by magnetic resonance imaging or visualization during surgery. If the examiner determines that the estimate for the anatomic impairment does not sufficiently reflect the severity of the patient's condition the examiner may increase the impairment percent explaining the reason for the increase in writing.' In this particular case, I would feel that the patient actually has a 15 percent impairment of the shoulder based on his known anatomic defects."

The Office subsequently requested that the district medical adviser review Dr. Blair's findings and provide calculations and a percentage of appellant's impairment according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). By letter dated May 8, 1998, the district medical adviser reported that appellant had full range of motion of his shoulders, and patients with his condition of rupture biceps tendon usually have no disability except for some minimal weakness of flexon, which he assessed would improve with time. He further stated that, although the attending physician empirically noted appellant as having a 15 percent permanent impairment of the right upper extremity, he noted that this rating was too high for a person who had a full range of motion and had returned to his former job. He noted appellant's permanent impairment at 10 percent of the right upper extremity.

In a letter dated August 31, 1998, the Office explained to appellant that a second medical examination was necessary to address the percentage of impairment of his injury, and arranged an examination with Dr. Edward Gold, a Board-certified orthopedic surgeon, on September 18, 1998. By letter dated September 9, 1998, the Office requested from Dr. Gold a narrative report, after evaluating appellant's right upper extremity using the A.M.A., *Guides*. The Office enclosed in the September 9, 1998 letter appellant's compensation medical records, a statement of accepted facts, specific questions to be answered upon evaluation and a worksheet upon which the physician was to record his findings.

On September 18, 1998 Dr. Gold completed the worksheet, indicating that appellant had reached maximum medical improvement on that date. He noted that appellant had been diagnosed with a rupture of the proximal end of the long head of the right biceps tendon and that physical therapy and oral medication had been used to regain his range of motion and strength. Dr. Gold further noted that appellant had returned to normal work duties except for avoiding heavy lifting and had been released from further care by his orthopedic surgeon. He diagnosed appellant's condition as traumatic rupture of the long head of the biceps tendon right shoulder. Dr. Gold represented the following percentage impairments on the worksheet provided by the Office: retained internal rotation of 20 degrees; retained external rotation of 85 degrees; retained forward elevation of 150 degrees; retained backward elevation of 35 degrees; retained abduction of 150 degrees; and retained adduction of 30 degrees. Dr. Gold concluded his report by recommending an impairment rating of 10 percent of the right upper extremity based on current motion, strength and potential subluxation according to the A.M.A., *Guides* 4th edition, Chapter 3.[1]

[1] A.M.A., *Guides* (4th ed. 1995) at 42-43.

By decision dated October 30, 1998, the Office issued to appellant a schedule award for the 10 percent permanent loss of use of his right arm.

Appellant disagreed with the October 30, 1998 decision and by letter dated November 11, 1998, requested review before this Board. Appellant contended that because the Office had accepted his claim, he should be compensated according to his physician's rating of 20 percent permanent impairment of the joint and 15 percent impairment of the shoulder initially submitted in support of his claim. Appellant contended that Dr. Blair's rating was in accordance with the A.M.A., *Guides* 4th edition.

The Board finds that the case is not in posture for a decision.

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[4] However, neither the Act nor its regulations specify the manner in which the percentage of loss of a member is to be determined. The method used in making such determination is a matter which rests within the sound discretion of the administering agency.[5] For consistent results and to ensure equal justice under the law to all claimants, the Office has adopted, and the Board has concurred in the adoption of, the use of a single set of tables so that there may be uniform standards applicable to all claimants seeking schedule awards. The A.M.A., *Guides* have been adopted by the Office for evaluating schedule losses.[6]

In the instant case, Dr. Blair noted in his April 2, 1998 report that appellant could not be rated on range of motion in the 4th edition A.M.A., *Guides* section 3.1M due to other disorders of the upper extremity previously suffered by appellant, and generally stated that there was no completely applicable portion of the A.M.A., *Guides* to rate appellant. However, Dr. Blair referred to Table 23 of the A.M.A., *Guides* and determined that there was a 15 to 20 percent loss of strength on the basis of the tendon rupture. Dr. Blair further recommended an impairment rating of 15 percent of the shoulder based on appellant's known anatomic defects, based upon the A.M.A., *Guides* notation that "[I]f the examiner determines that the estimate for the anatomic impairment does not sufficiently reflect the severity of the patient's condition, the examiner may increase the impairment percent, explaining the reason for the increase in writing." Dr. Blair offered no explanation, however, as to why he believed appellant's rotator cuff tear was so severe that the objective measurements of appellant's loss of function would not reflect the degree of his impairment.[7] His evaluation of 15 percent impairment was presumably rated

[2] 5 U.S.C. §§ 8101-8193; 5 U.S.C. § 8107(c).

[3] 20 C.F.R. § 10.304.

[4] 5 U.S.C. § 8107(c)(19).

[5] *Danniel C. Goings*, 37 ECAB 781, 783 (1987); *Richard Beggs*, 28 ECAB 387, 390-91 (1977).

[6] *See, e.g., Leisa D. Vassar,* 40 ECAB 1287, 1289-90 (1989).

[7] A.M.A., *Guides, supra* note 1 at 64.

higher due to the severity of his condition, but without a rationale, his report does not provide a reliable estimate of the extent of appellant's permanent impairment.

On May 8, 1998 the Office medical adviser reviewed the April 2, 1998 report and disagreed with Dr. Blair's findings. The Office medical adviser indicated in his May 8, 1998 note that Dr. Blair's rating of 15 percent of the right upper extremity was too high for a person who had full range of motion in this area and had returned to normal work duties. The Office medical adviser estimated appellant's permanent impairment as 10 percent but did not make any citation to the A.M.A., *Guides* with regard to his assessment.

The Office noted in the record the discrepancy between the two reports, and therefore authorized the second opinion conducted by Dr. Gold who provided appellant's ranges of motion by completing the worksheet provided by the Office; however, he did not refer to the appropriate tables of the A.M.A., *Guides* in making his impairment rating of 10 percent.

None of the medical reports of record reflect an impairment evaluation of appellant conforming with the A.M.A., *Guides*. The Office should have obtained a medical report that correlated the results of a medical evaluation and analysis with the A.M.A., *Guides*.

Because the medical evidence of record is incomplete, the case will be remanded for further development to properly determine the nature of appellant's impairment. On remand the Office shall refer appellant to an appropriate specialist for an examination and a permanent impairment rating that correlates with the A.M.A., *Guides*, to be followed by a *de novo* decision.

The decision of the Office of Workers' Compensation Programs dated October 30, 1998 is set aside and the case remanded for further proceedings consistent with this decision.

Dated, Washington, D.C.
May 10, 2000

Michael J. Walsh
Chairman

George E. Rivers
Member

Michael E. Groom
Alternate Member